Medicare

Q&A

85 COMMONLY ASKED QUESTIONS

Including a special section on Medicare and Coordinated Care Plans

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FREE PUBLICATIONS

The following publications may be obtained from any Social Security office or by writing to:

Medicare Publications
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

- ☐ The Medicare Handbook
- ☐ Guide to Health Insurance for People with Medicare
- ☐ Medicare and Coordinated Care Plans
- ☐ Medicare Hospice Benefits
- ☐ Medicare and Other Health Benefits
- ☐ Medicare Coverage for Second Surgical Opinion
- ☐ Medicare Coverage of Kidney Dialysis and Kidney Transplant Services
- ☐ Medicare and Advance Directives
- ☐ Medicare and Your Physician's Bill
- ☐ Medicare Savings for Qualified Beneficiaries

This booklet is meant to provide information about the Medicare program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

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COMMONLY ASKED QUESTIONS ABOUT MEDICARE

Q. What is Medicare?

A. Medicare is a Federal health insurance program established in 1965 for people aged 65 or older. It now also covers people of any age with permanent kidney failure, and certain disabled people. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. Local Social Security Administration offices take applications for Medicare entitlement and provide information about the program.

Q. What is the difference between Medicare and Medicaid?

A. Medicare is a Federal health insurance program for the elderly and disabled regardless of income and assets. Medicaid, on the other hand, is a medical assistance program jointly financed by the State and Federal governments for eligible low-income individuals. Medicaid covers health care expenses for all recipients of Aid to Families with Dependent Children (AFDC), and most States also cover the needy elderly, blind, and disabled who receive cash assistance under the Supplemental Security Income (SSI) program. Coverage also is extended to certain infants and low-income pregnant women, and, at the option of the State, other low-income individuals with medical bills who qualify as categorically or medically needy.

Q. How many people are covered by Medicare?

A. Medicare currently covers approximately 36 million persons, of whom about 3 million are disabled and some 200,000 are end-stage renal disease patients.

Q. What does Medicare cover?

A. Medicare has two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). They are commonly called Part A and Part B because Medicare Hospital Insurance coverage is described in Part A, and Medical Insurance coverage in Part B, of Title XVIII of the Social Security Act. Part A helps pay for inpatient care in a hospital or skilled nursing facility or for care from a home health agency or hospice. If you are admitted to a hospital, Medicare provides coverage for a semi-private room, meals, regular nursing services, operating and recovery room costs, intensive care, drugs, lab tests, X-rays, and all other medically necessary services and supplies. Covered services in a skilled

Medicare And Medicaid

Medicare Population

Your Medicare Coverage

nursing facility include a semi-private room, meals, regular nursing services, rehabilitation services, drugs, and medical supplies and appliances.

Part B helps pay for physician services, outpatient hospital care, clinical laboratory tests, and various other medical services and supplies, including durable medical equipment. Doctors' services are covered no matter where you receive them in the U.S. Covered services include surgical services, diagnostic tests and X-rays that are part of your treatment, medical supplies furnished in a doctor's office, and drugs which cannot be self-administered and are part of your treatment. Medicare pays only for care that it determines is medically necessary.

What Medicare Doesn't Cover

Q. Are there services Medicare does not cover?

A. While Medicare helps pay a large portion of your medical expenses, there are various health care services and products for which Medicare will not pay. These generally include custodial care; eyeglasses, hearing aids, and examinations to prescribe or fit them; a telephone, TV, or radio in your hospital room; and most outpatient prescription drugs and patent medicines. Medicare also does not pay for cosmetic surgery, most immunizations, dental care, routine foot care, and routine physical checkups. Although some personal care services (for example: bathing assistance, eating assistance, etc.) can be covered as part of any skilled care you receive, they are never covered alone except under the hospice benefit.

Paying For Medicare

Q. How is Medicare financed?

A. Medicare Hospital Insurance (Part A) is financed mainly from a portion of the Social Security payroll tax (the FICA) deduction. The Medicare part of the payroll tax is 1.45 percent from the employee and 1.45 percent from the employer on wages up to $135,000 in 1993. Medicare Supplementary Medical Insurance (Part B), which is optional, is financed by the monthly premiums paid by enrollees and from Federal general revenues. The monthly premium, which is subject to change annually, is $36.60 in 1993. The premium pays about 25 percent of the cost of the Part B program and general tax revenues pay about 75 percent.

Who's Eligible?

Q. Who is eligible for Medicare?

A. Generally, people age 65 and over can get Part A benefits if they can establish their eligibility for monthly Social Security or Railroad Retirement benefits on their own or their spouse's work record. In addition, certain government employees whose work has been covered

for Medicare purposes, and their spouses, can also have Part A. In rare cases, involving those who became age 65 in 1974 or earlier, Part A may be available if these people meet certain United States residence and citizenship or legal alien requirements.
Part A is also available to most individuals with permanent kidney failure, and to those who have been entitled to Social Security disability benefits or Railroad Retirement disability benefits for more than 24 months, and to certain disabled government employees whose work has been covered for Medicare purposes. Any person who is eligible for Part A is also eligible to enroll in Part B.

Medicare Enrollment

Q. How do I sign up for Medicare?

A. If you are already getting Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically get a Medicare card in the mail. The card will usually show that you are entitled to both Part A and Part B and indicate the beginning dates of your entitlement to each. If you do not want Part B, you can refuse it by following the instructions that come with the card. If you are not receiving Social Security or Railroad retirement benefits when you turn 65, you may have to apply for Medicare coverage. Check with any Social Security Administration office to see if you are able to get Medicare under the Social Security system or based on Medicare-covered government employment; check with the Railroad Retirement office if you are able to get Medicare under the Railroad Retirement system. If you must file an application for Medicare, you should do so during your initial seven-month enrollment period. That period starts three months before the month you first meet the requirements for Medicare.

Getting More Information

Q. Whom do I call to get more information about Medicare?

A. If you want to know how and when to sign up for Medicare, or how to change an address or replace a lost Medicare card, contact any Social Security Administration office.

Enrolling Late For Part B

Q. When I enrolled in Medicare Part A, I did not sign up for Part B. Is that coverage still available to me on the same terms?

A. You may still enroll in Part B during the annual general enrollment period from January 1 to March 31, and your coverage will begin on July 1 of the year you enroll. Your monthly premium likely will be higher than it would have been had you enrolled in Part B when you enrolled in Part A. Generally, if you defer your enrollment in Part B, you must pay a monthly premium surcharge. The surcharge is 10 percent for each 12-month period in which they could have been enrolled but were not. The surcharge generally does not apply if you

delayed enrolling in Part B because you were covered by an employer health plan based on your or your spouse's current employment since you first became eligible for Medicare. In that case, you would be allowed to enroll in Part B during a special 7-month enrollment period. The period begins with the month the employer group health plan coverage ends, or with the month the employment on which it is based ends, whichever is earlier. In the case of certain disability beneficiaries, the special period begins when Medicare replaces the employer group health plan as the primary payer of the beneficiary's covered medical services.

Do You Have Both Part A & B Coverage?

Q. How do I know whether I'm covered by one or both parts of Medicare?

A. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your coverage started.

Your Medicare Claim Number

Q. What does the letter(s) that appears after my health insurance claim number on my Medicare card mean?

A. It is a code used by the Social Security Administration to indicate the type of benefits you are receiving. There may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence.

Q. If I am not entitled to Medicare based on my employment or the employment of my spouse, can I buy the coverage?

A. Individuals age 65 or over who are United States residents and *either* United States citizens or aliens who have been lawfully admitted for permanent residence and have resided in the United States for at least five years at the time of filing, can purchase both Part A and Part B, or just Part B. The monthly premiums in 1993 are $221 for Part A and $36.60 for Part B.

Getting Medicare-Covered Care

Q. Are there different health care systems Medicare beneficiaries can use to get their Medicare benefits?

A. Yes. You can receive services covered by Medicare either through the traditional fee-for-service (pay-as-you-go) delivery system or through coordinated care plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs), which have contracts with Medicare. (Most of the information in this section pertains to fee-for-service health care. For information about Medicare and coordinated care plans turn to page 19.)

Q. How do fee-for-service and coordinated care differ?

A. Whether you choose fee-for-service or coordinated care, you get all of Medicare's hospital and medical benefits if you are enrolled in both Part A and Part B. The care provided by both systems is comparable. The differences in the two systems relate to how the benefits are delivered, how and when payment is made, the amount of paperwork you may be required to submit, and how much you might have to pay out of your pocket.

Under the fee-for-service health care system you have freedom of choice. You can choose any licensed physician and use the services of any hospital, health care provider, or facility approved by Medicare that agrees to accept you as a patient. Generally a fee is paid each time a service is used. Medicare, within certain limits, pays a large portion of the hospital, physician, and other health care expenses.

In a coordinated care plan (HMO or CMP) a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) generally offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in an emergency, services usually must be obtained from the health care professionals and facilities that are part of the plan. Depending on how the plan is organized, care is provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

Fee-For-Service VS. Coordinated Care

Q. Do Medicare beneficiaries have to pay any charges out of their own pockets when they use covered services?

A. Yes. Under the fee-for-service system, both Part A and Part B have deductible and coinsurance amounts for which you are liable. You also must pay all permissible charges in excess of Medicare's approved amounts for Part B services and charges for services not covered by Medicare. These charges do not apply to coordinated care plan enrollees. If you enroll in a coordinated care plan, Medicare makes a payment to the plan to provide you with all of the services covered by Medicare. In addition, plans may charge a nominal copayment at the time a service is used, and most charge a monthly premium in place of the usual Medicare coinsurance and deductibles.

Charges You Pay

Q. Is assistance available to help low-income Medicare beneficiaries pay Medicare's premiums, deductibles and coinsurance amounts?

A. Yes. If your annual income is at or below the national poverty level and you have limited financial resources, you may qualify for government assistance under your state's Medicaid program in covering Medicare monthly premiums, deductibles and coinsurance. To qualify, your income in 1993 must be less than $601 per month for one person or $806 per month for a couple, except in Alaska and Hawaii.

Help For Low-Income Beneficiaries

In Alaska the income limits are $745 per month for one person and $1,002 per month for a couple. In Hawaii they are $690 per month for on person and $925 per month for a couple. Income includes Social Security benefits, pensions and wages. Interest payments and dividends can also count as income. In addition, you must be entitled to Medicare Hospital Insurance (Part A), and your financial resources such as bank accounts, stocks and bonds, cannot be more than $4,000 for one person or $6,000 for a couple. If you think you qualify, you should contact your state or local welfare, social service or public health agency and ask about the "Qualified Medicare Beneficiary (QMB) program or the "Medicare Buy-in" program. If you need the telephone number for your state medical assistance office, call: **1-800-638-6833.** You can also get a leaflet explaining the QMB benefit by calling this number.

"SLME" Program Offers Assistance

Q. Is financial assistance available to persons whose incomes are slightly above the national poverty levels?

A. Yes. Depending on your income and assets, your State Medicaid program may pay your Medicare Part B premium, which is $36.60 per month in 1993. You might qualify for this limited assistance if your income in 1993 is not more than $659 a month for one person or $884 a month for a couple, except in Alaska and Hawaii. In Alaska, the limits are $818 per month for one person and $1,100 for a couple. In Hawaii, the limits are $758 per month for one person and $1,016 per month for a couple. In addition, you must be entitled to Medicare Part A and your financial resources such as bank accounts, stocks and bonds cannot exceed $4,000 for one person or $6,000 for a couple. If you think you qualify for this assistance, follow the same application procedure as is explained at the end of the previous answer. This is called the "Specified Low-income Medicare Beneficiaries" (SLMB) program.

Part B Deductible And Coinsurance Amounts

Q. How much are the Part B deductible and coinsurance amounts?

A. The Medicare Part B deductible is $100 per calendar year. This means that you are responsible for the first $100 of Medicare-approved expenses for physician and other medical services and supplies. The deductible is charged to you when you first receive Medicare-covered services. You do not have to actually pay the $100 before Medicare starts paying it share of covered services after the deductible is met. You only have to incur $100 in covered charges, and the charges must be based on Medicare's approved amounts for the services you received, not on what the doctor charged if the charges are more the approved amounts. After the deductible has been met, then Medicare starts paying. Medicare generally pays 80 percent of all other approved charges for covered services for the rest of the year. You are

responsible for the other 20 percent, which is called coinsurance. If your physician or supplier does not accept assignment of your Medicare claim (that is, accept Medicare's approved amount as payment in full), you are responsible for all permissible charges in excess of the approved amount. You also generally are liable for charges for services not covered by Medicare. There is no deductible or coinsurance for home health services. You do, however, have to pay 20 percent of the Medicare-approved amount for durable medical equipment supplied under the home health benefit.

Part A Deductible And Coinsurance Amounts

Q. How much are the Part A deductible and coinsurance amounts?

A. The Part A deductible is $676 per benefit period in 1993. Because the Part A deductible applies to each benefit period, you could have to pay more than one deductible in a year if you were hospitalized more than once. After you meet the first $676 of Medicare-covered expenses in each benefit period, Medicare pays all covered expenses for the first 60 days. For days 61 through 90, Medicare pays all covered expenses except for a coinsurance amount of $169 per day in 1993. You are responsible for the $169 per day. Whenever more than 90 days of inpatient hospital care are needed in a benefit period, you can use your lifetime reserve days to pay for covered services from the 91st through the 150th day. Every person enrolled in Part A has a lifetime reserve of 60 days for inpatient hospital care. Once used, these days are not renewed. When a reserve day is used, Medicare pays for all covered services except for a coinsurance amount of $338 a day in 1993. You are responsible for the $338 daily charge.

Skilled Nursing Facility Care

Q. What if I require care in a skilled nursing facility after leaving the hospital?

A. If, within a short time period (generally, 30 days) after being in a hospital for at least three days, you receive covered care in a skilled nursing facility that has been approved to participate in the Medicare program, Part A will help cover services for up to 100 days per benefit period. Medicare pays all covered expenses for the first 20 days and all but $84.50 per day in 1993 for the next 80 days. You are responsible for the $84.50 per day. Beginning with the 101st day of skilled nursing facility care in any benefit period, you are responsible for all charges.

Benefit Period

Q. What is a benefit period?

A. A benefit period is a way of measuring your use of hospital and skilled nursing facility services covered by Medicare Part A. A benefit period begins the day you are hospitalized and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row. If you are hospitalized after 60 days, a new benefit period begins and your days of covered care are renewed except for any lifetime reserve days that you may have used for hospital care. In each new benefit period you are responsible for paying Medicare's deductible and coinsurance amounts. Here's how benefit periods work: Suppose you were admitted to the hospital on January 1 and two weeks later you were discharged only to be readmitted on February 20. Since fewer than 60 days had passed between the discharge and readmission dates, you would be in the same benefit period and would not have to pay the $676 Part A deductible again. Additionally, you would be in the 15th day of covered hospital care for the benefit period. However, if instead of being readmitted on February 20, you were readmitted May 3, more than 60 days would have elapsed since your discharge from the hospital and you would be in a new benefit period. In that case, you would have to pay a second $676 Part A deductible, but your coverage would start from day one instead of day 15. There is no limit to the number of benefit periods you can have.

Processing Medicare Claims

Q. Who processes Medicare claims and payments?

A. Medicare claims and payments are handled by insurance organizations under contract to the Federal government. The organizations handling claims from hospitals, skilled nursing facilities, home health agencies, and hospices are called "intermediaries." You almost never have to get involved in the Part A claims process. The insurance organizations that handle Medicare's Part B claims are called "carriers." The names and addresses of the carriers and areas they serve are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Medicare Approved Amount

Q. How does Medicare determine its approved amounts for physician services?

A. Medicare's system for paying physicians is based on a national fee schedule. The schedule, which went into effect on January 1, 1992, assigns a dollar value to each physician service based on work, medical practice costs, and malpractice insurance costs. Each of these three factors is adjusted for the geographic variation in costs. The fees that appear on the schedule are the Medicare-approved amounts for the some 7,000 physician services covered by Medicare. Each time you go to a physician for a covered service, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount after you have met the annual Part B deductible. You are responsible for the other 20 percent as well as all permissible charges in excess of the Medicare-approved amount.

Q. What does it mean when a physician accepts assignment?

A. Physicians and suppliers who accept assignment of Medicare claims agree to *not* charge more than the Medicare approved amount for services and supplies covered by Part B. They are paid directly by Medicare, except for the deductible and coinsurance amounts for which you are responsible. Some physicians and suppliers have signed agreements to participate in Medicare. In doing so, they have agreed to accept assignment of Medicare claims all of the time. Other physicians and suppliers will accept assignment on a case-by-case basis or not at all.

Accepting Medicare Assignment

Q. What if a physician does not accept assignment of a Medicare claim?

A. Physicians and suppliers who do not accept assignment of Medicare claims may charge more than the Medicare approved amount and collect full payment directly from you. Medicare then pays you 80 percent of the approved amount for the covered service, less any unmet portion of the $100 Part B deductible. You are liable for the balance of the bill, including all permissible charges in excess of Medicare's approved amount.

Physicians Who Don't Accept Assignment

Q. Is there a limit to the amount a physician who does not accept assignment can charge a Medicare beneficiary for a covered service?

A. Yes. In 1993 and thereafter, the most you can be charged is 115 percent of the Medicare fee schedule amount for nonparticipating physicians. Here's a comparison of your share of the cost for the same service provided by a participating physician and by a nonparticipating physician who did not accept assignment of your Medicare claim:

If you went to a participating physician for a service for which the fee schedule amount was $100, the physician would accept that amount as payment in full. Medicare would pay 80 percent, or $80, and you would be responsible for 20 percent, or $20, assuming you had already met the Part B $100 annual deductible.

For the same service furnished by a nonparticipating physician, the fee schedule amount would be $95. (Nonparticipating physicians are reimbursed at 95 percent of the fee schedule amount for participating physicians.) Medicare would pay $76, or 80 percent, leaving you with a balance of $19 to cover the remaining 20 percent of the fee schedule amount. Since nonparticipating physicians who do not accept assignment can legally charge 15 percent more than the fee schedule amount, another $14.25 could be added to the bill, bringing your out-of-pocket cost to $33.25, assuming you had already met the Part B deductible. You would not have to pay any charges over $33.25.

Limiting A Physician's Charges

To find out what the limiting charge is for a particular service, you can contact your Medicare carrier. Limiting charge information will also appear on the "Explanation of Your Medicare Part B Benefits" (EOMB) notice when you receive medical services covered by Medicare. If you think your physician has exceeded the charge limits, you may want to first contact the physician and ask for a reduction in the charge. If you cannot satisfactorily settle the issue with the physician, you can call the Medicare carrier and request an investigation. If it appears to the carrier that you were overcharged, the carrier will contact the physician and ask for a refund of any overpayment you may have made. Sanctions can be imposed against any physician who knowingly and willfully, and on a repeated basis, charges Medicare beneficiaries more than the legal limit. Besides the charge limitations mandated by Federal law, some States also limit physician charges.

Finding A Participating Physician

Q. How can I find a Medicare-participating physician or supplier?

A. The names and addresses of Medicare-participating physicians and suppliers are listed by geographic area in the *Medicare-Participating Physician/Supplier Directory*. You can get the directory for your area free of charge from your Medicare carrier (listed in the back of *The Medicare Handbook*) or you can call your carrier and ask for names of some participating physicians and suppliers in your area. This directory is also available for review in Social Security Administration offices, State and area offices of the Administration on Aging, and in most hospitals. Physicians and suppliers are given the opportunity each year to sign Medicare participation agreements.

Filling A Part B Claim

Q. When a physician provides Medicare-covered services to a Medicare beneficiary, does the physician or beneficiary file the claim with the Medicare carrier for payment?

A. For Medicare-covered services and supplies furnished on or after September 1, 1990, the physician or supplier is required to submit the claim for the beneficiary. For services and supplies provided prior to that date, the physician or supplier was not required to submit the claim unless the physician or supplier participated in Medicare or had agreed to accept assignment of the claim.

What to do When You Have A Problem With A Claim

Q. Whom do I call if I have a question about a Medicare claim for a physician's services?

A. Call the Medicare carrier for the area where the service was provided. That carrier, which may not be the carrier for your State, is responsible for processing the claim. The carrier's name and toll-free telephone number are listed in the back of *The Medicare Handbook*

and appear on the Explanation of Your Medicare Part B Benefits notice.

Q. How long should I wait before contacting the Medicare carrier to check on the status of a claim?

A. Allow 30 to 45 days for the claim to be paid. If you have not received a check or an Explanation of Your Medicare Part B Benefits payment statement after 45 days, call the Medicare carrier.

Checking On A Claim

Q. What can I do if Medicare denies payment for a claim or pays less than I think it should?

A. You have a right to appeal Medicare's coverage and payment determinations for both the hospital (Part A) and medical (Part B) parts of Medicare. The appeals processes are explained in *The Medicare Handbook*.

Appealing A Claims Payment Decision

Q. Does Medicare cover ambulance services?

A. Medicare Part B can help pay for certain medically necessary ambulance services when: (1) the ambulance, equipment, and personnel meet Medicare requirements; and (2) transportation by any other means would endanger your health. This includes transportation from you home to a hospital, from a hospital to a skilled nursing facility, or from a hospital or skilled nursing facility to your home. Medicare will also cover a round trip from a hospital or a participating skilled nursing facility to an outside supplier to obtain medically necessary diagnostic or therapeutic services not available at the hospital or skilled nursing facility where you are an inpatient.

Ambulance Services

Q. Does Medicare cover prostheses and medical devices?

A. Yes. Medicare also covers cardiac pacemakers, corrective lenses needed after cataract surgery, colostomy or ileostomy supplies, breast prostheses following a mastectomy, and artificial limbs and eyes. Coverage also is provided for durable medical equipment, such as wheelchairs, hospital beds, walkers, and other equipment prescribed by a doctor for home use.

Medicare Coverage For Wheelchairs, Pacemakers, And Artificial Limbs

Q. Does Medicare pay for long-term care in a nursing home?

A. No. Medicare helps pay for post-hospital extended care only in a skilled nursing facility (SNF). A SNF is a specially qualified facility with the staff and equipment to provide skilled nursing care, a full range of rehabilitation therapies, and related health services. Medicare

Nursing Home Care Not Covered By Medicare

only pays when a skilled level of care is required as a continuation of a hospital stay and the care is provided in a SNF that participates in Medicare. The hospital stay must have been for at least three days, not counting the day of discharge, and your admittance to the SNF generally must be within 30 days of the hospital discharge. Even if you are in a SNF that participates in Medicare, Medicare will not pay if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, and bathing. A SNF that participates in Medicare will inform you at the time of admission about potential Medicare payment and your rights to seek payment.

Chiropractic Services

Q. Will Medicare pay for a chiropractor's services?

A. When furnished by a licensed chiropractor, Medicare will help pay for the manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. That is the only chiropractic service covered by Medicare.

Psychiatric Coverage

Q. Does Medicare pay for care in a psychiatric hospital?

A. Yes. Medicare Part A helps pay for up to 190 days of inpatient care in a participating psychiatric hospital during a beneficiary's lifetime. However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Checking For Cancer

Q. Does Medicare pay for cervical- and breast-cancer screenings?

A. Yes. Medicare Part B helps pay for Pap smears to screen for the detection of cervical cancer and for X-ray screenings (mammograms) for the detection of breast cancer.

Home Health Care

Q. Does Medicare cover home health care?

A. Yes. If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. To qualify, you must be homebound, need intermittent skilled nursing care, or physical therapy, or speech therapy. You also must be under the care of a physician who determines you need home health care and sets up a home health care plan for you. You do not have to pay a deductible or coinsurance when you receive home health care covered by Medicare, with the exception of a 20 percent copayment on durable medical equipment.

Q. How long can home health care last?

A. Home health care can continue for as long as you are under a physician's plan of care and as long as you continue to meet the eligibility criteria mentioned above. Home health aide services are also available if you are eligible. Daily skilled care is available on a limited basis to those beneficiaries who qualify. However, Medicare will not pay for round-the-clock home health care.

Coverage Limits

Q. How much does Medicare pay toward the cost of home health care?

A. Medicare pays the full approved cost of all covered home health visits. There is no coinsurance on home health care. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent coinsurance payment for the equipment.

Who Pays For Home Health Care?

Q. What is hospice care?

A. Hospice is a special way of caring for a patient whose disease cannot be cured and whose medical life expectancy is six months or less if the disease runs its normal course. Patients receive a full scope of palliative medical and support services for their terminal illnesses.

Q. Is hospice care available to Medicare beneficiaries?

A. Yes. Medicare beneficiaries certified by a physician to be terminally ill may elect to receive hospice care from a Medicare-approved hospice program. Under Medicare, hospice is primarily a comprehensive home care program that provides medical and support services for the management of a terminal illness. Beneficiaries who elect hospice care are not permitted to use standard Medicare to cover services for the treatment of conditions related to the terminal illness. Standard Medicare benefits are provided, however, for the treatment of conditions unrelated to the terminal illness. Medicare has special benefit periods for beneficiaries who enroll in a hospice program.

Medicare And Hospice Care

Q. What are Peer Review Organizations (PROs)?

A. The Federal Government contracts with physician-directed Peer Review Organizations (PROs) in each State to ensure that Medicare beneficiaries receive care which is medically necessary, reasonable, provided in the most appropriate setting, and meets professionally accepted standards of quality. Among other things, PROs, through case review and other activities, work cooperatively with physicians and health care facilities to improve Medicare beneficiary care. They ensure that beneficiaries are advised of their appeal rights and review

PROs

all written complaints from beneficiaries or their representatives concerning the quality of care rendered. If you are admitted to a hospital, you will receive a notice explaining your rights under Medicare and how to contact the PRO if the need arises.

Advance Directive

Q. As a Medicare beneficiary, can I prepare a written statement explaining what care I want or do not want in the event I become physically or mentally unable to communicate my wishes?

A. Yes. All adults in hospitals, skilled nursing facilities, and health care settings have certain rights. For example, you have a right to confidentiality of your personal and medical records and to know what treatment you will receive. You also have the right to prepare a document called an "advance directive." In one type of advance directive ("living will"), you state in advance what kind of treatment you want or do not want if you become incapacitated. In a second type ("durable power of attorney"), you authorize another person to make those decisions for you if you are unable to do so yourself. Federal law requires hospitals, skilled nursing facilities, hospices, home health agencies and health maintenance organizations (HMOs) serving persons covered by either Medicare or Medicaid to provide information about advance directives and explain the patient's legal choices in making decisions about medical care.

Medicare And Foreign Travel

Q. If I require medical services outside the United States and its territories, will Medicare pay the bills?

A. No, except in three situations. Medicare will help pay for care in qualified Canadian or Mexican hospitals if:

(1) You are in the United States when an emergency occurs, and a Canadian or Mexican hospital is closer to, or substantially more accessible from, the site of the emergency than the nearest U.S. hospital that can provide the emergency services you need.

(2) You live in the United States and a Canadian or Mexican hospital is closer to, or substantially more accessible from, your home than the nearest U.S. hospital that can provide the care you need, regardless of whether an emergency exists, and without regard to where the illness or injury occurs.

(3) You are in Canada travelling by the most direct route between Alaska and another State when an emergency occurs, and a Canadian hospital is closer to, or substantially more accessible from, the site of the emergency than the nearest U.S. hospital that can provide the emergency services you need.

Who Pays First?

Q. Is Medicare always the primary payer of a beneficiary's medical bills or are there situations when another insurer must pay first?

A. No, Medicare is not always the primary payer. There are a number of situations in which another insurer is the primary payer of your health care costs and Medicare is the secondary payer. For example, Medicare may be the secondary payer if you are covered by an employer group health insurance plan, are entitled to veterans benefits, workers' compensation, or black lung benefits. Medicare also can be the secondary payer if no-fault insurance or liability insurance (such as automobile insurance) is available as the primary payer. In cases where Medicare is the secondary payer, Medicare may pay some or all of the charges not paid by the primary payer for services and supplies covered by Medicare. This issue is discussed in more detail in the publication titled "Medicare Secondary Payer," available from any Social Security office.

Medigap Insurance

Q. What is "Medigap" insurance?

A. Medigap insurance is private health insurance designed specifically to supplement Medicare's benefits by filling in some of Medicare's coverage. A Medigap policy generally pays for Medicare approved charges not paid by Medicare because of deductibles or coinsurance amounts for which you are responsible. There are Federal minimum standards for such policies which the states include as part of their programs to regulate Medigap policies. Most States limit the Medigap insurance market to no more than 10 standard policies. One of the 10 is a basic policy offering a "core package" of benefits. The other nine have a different combination of benefits but they all include the core package. Insurers are not permitted to change the combination of benefits in any of the 10 standard policies. While a State may limit the number of plans sold in the state to fewer than 10, each State must ensure that the basic policy is approved for sale in the State. Medigap insurers are not required to offer all of the plans approved for sale in each of the individual States, but each must offer the basic policy. For more information on this subject, contact your State insurance department or Social Security Office and ask for a free copy of the *Guide to Health Insurance for People With Medicare*.

Changing Medigap Policies

Q. If I bought a Medigap policy before regulations standardizing these policies went into effect in 1992, do I have to switch to one of the new standard policies?

A. Depending on which State you live in, you may not have to switch to one of the 10 standard plans, especially if your older policy is guaranteed renewable. Some States, however, have specific requirements that affect existing non-standard policies. For example, some

States require or permit insurers to convert older policies to the new standardized plans. Check with your State insurance department to find out what State-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the new Medigap policies if it is to your advantage and an insurer is willing to sell you one. Before replacing an old policy with one of the new standard policies, compare the benefits and the premiums. You will not be permitted to go back to the old policy once you switch.

Gaps In Your Medicare Coverage

Q. What are the "gaps" in Medicare coverage?

A. In general, they are charges for which you are responsible. They include Medicare's deductibles and coinsurance amounts, permissible charges in excess of Medicare's approved amounts, additional days of care in a hospital or skilled nursing facility, and the charges for the various health care services and supplies that Medicare does not cover. Medigap insurance can cover some or most of these charges, depending on the policy.

One Medigap Policy Is Enough

Q. Do I need more than one Medigap policy?

A. No. One good policy tailored to your needs at a price you can afford is sufficient. It is unlawful for an insurance company or agent to sell you a Medigap policy that duplicates coverage that you already have. A replacement Medigap policy can be sold to you lawfully only if you state in writing that the policy you already have will be cancelled. Medicare beneficiaries enrolled in coordinated care plans (HMOs and CMPs) or who are eligible for Medicaid usually do not need Medigap insurance and, under the law, it could be unlawful for anyone to sell them Medigap insurance because it would duplicate their health care coverage. Also, if you have insurance from an employer or labor union, you may not need Medigap insurance and cannot legally be sold a Medigap policy unless you promise to drop the other coverage.

Medicare Select

Q. What is Medicare SELECT insurance?

A. Medicare SELECT is a Medigap insurance product that may be available in designated States through either HMOs or insurance companies. The States where these policies are currently authorized to be sold are Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. During a three-year period (1992-1994) authorized under Federal law, Medicare SELECT will be evaluated to determine how it should be made available throughout the Nation.

Medigap And Medicare Select

Q. What is the difference between Medicare SELECT and other Medigap insurance?

A. Anyone who buys Medicare SELECT is buying one of 10 standard Medigap plans. The only difference is that Medicare SELECT policies will only pay full supplemental benefits if covered services are obtained through specified health care professionals. Medicare SELECT policies are expected to have lower premiums because of this limitation. The health care professionals, called "preferred providers," are selected by the insurers. Each insurer that offers a Medicare SELECT policy, whether it be an insurance company or an HMO, has its own network of preferred providers. Except in emergencies, policyholders are required to use a preferred provider if the insurer is to pay full benefits. Medicare, however, pays its portion of covered benefits regardless of whether a preferred provider is used.

Your Right To Medigap Insurance

Q. Do I have a right under law to purchase a Medigap policy?

A. Yes, under certain circumstances. Federal law, which applies to all Medigap policies becoming effective after November 5, 1991, guarantees that for 6 months immediately following enrollment in Medicare Medical Insurance (Part B), persons aged 65 or older cannot be denied Medigap insurance. If you want to buy a policy during your six-month open-enrollment period, the company must offer you all the different types of Medigap policies it sells. It cannot delay the issuance or effective date of the policy, charge you more, or discriminate in any other manner because of your health status or claims experience.

Getting More Information About Supplemental Insurance

Q. Where can I get more information about insurance to supplement my Medicare benefits?

A. Contact any Social Security Administration office, State office on aging, or your State insurance department and ask for a copy of the *Guide to Health Insurance for People with Medicare*. It describes Medicare's benefits and the types of private insurance available to supplement Medicare.

Insurance Counseling

Q. Can I call someone for advice on which Medigap policy is best for me?

A. Yes. All States except Mississippi already offer insurance counseling or are in the process of establishing programs either through the State department of insurance or agency on aging. Information on counseling services is contained in the *Guide to Health Insurance for People With Medicare*.

Medigap Complaints

Q. Whom should I contact if I have a complaint about the agent who sold me a Medigap policy?

A. Suspected violations of the laws governing the sales and marketing of Medigap policies should be reported to your State insurance department or Federal authorities. The Federal toll-free telephone number for registering such complaints is 1-800-638-6833.

Second Surgical Opinions

Q. Whom do I call if I want a second surgical opinion?

A. If your physician has recommended surgery for a non-emergency condition covered by Medicare and you want the names of doctors in your area who provide second opinions for elective surgery, call your Medicare carrier. Many physical conditions that do not require immediate attention can be treated equally well without surgery.

Reporting Fraud

Q. Where do I report suspected cases of Medicare fraud?

A. If you have evidence of or suspect fraud or abuse of the Medicare or Medicaid programs, call your Medicare carrier.

Changing Your Address

Q. I moved. How do I get my address changed?

A. You should call your local Social Security office and ask that your records be changed to reflect your new address.

New Benefits

Q. Was Medicare coverage expanded in 1993?

A. Yes. Medicare will now pay for flu shots and reimburse the cost of therapeutic shoes for beneficiaries suffering from severe diabetic foot disease.

Dental Benefits

Q. Does Medicare pay for dental services?

A. Medicare generally does **not** pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare **does** help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them.

MEDICARE AND COORDINATED CARE PLANS

The following questions and answers pertain to coordinated care plans that have contracts with the Health Care Financing Administration to provide health care services to Medicare beneficiaries. In addition to being called coordinated care plans, they also are known as prepaid or managed care plans. The most common types of coordinated care plans are health maintenance organizations (HMOs) and competitive medical plans (CMPs). Many HMOs and CMPs are under contract to serve Medicare beneficiaries, and there are such plans in most parts of the country. For help in finding a plan turn to page 26.

Who Can Enroll In A Plan

Q. Can I enroll in a coordinated care plan?

A. Most Medicare beneficiaries are eligible for enrollment in a coordinated care plan. Plans under contract with HCFA cannot refuse to enroll you because of any health problem you may have or delay coverage for a pre-existing condition. The only enrollment requirements are:

- You must at least be enrolled in Medicare Supplementary Medical Insurance (Part B) and continue to pay the Part B monthly premium.
- You must live within the area in which the plan has agreed to provide services.
- You cannot have elected to receive care from a Medicare-certified hospice.
- You cannot have been medically determined to have end-stage renal disease (ESRD). However, if you are a member of a coordinated care plan when you first become eligible for Medicare and the plan has a Medicare contract, you may **change** to Medicare membership with the plan even if you have ESRD.

When To Enroll

Q. When can I enroll in a plan?

A. Each plan contracting with Medicare must have an open enrollment period at least once a year for a minimum of 30 days. You may enroll during any open enrollment period.

Disenrolling

Q. If I enroll in a coordinated care plan, can I later return to fee-for-service Medicare coverage?

A. Yes. You may disenroll from a coordinated care plan at any time. Your coverage under fee-for-service Medicare will begin the first day of the following month. You may also change from one plan to another simply by enrolling in the second plan.

Plan Benefits

Q. What benefits will I receive as member of a coordinated care plan?

A. The plan is required to provide or arrange for you to receive all Medicare hospital and medical benefits if you are covered by both Medicare Part A and Part B. If you only have Part B, your coverage will be limited to medical services covered by Part B.

What If I Don't Have Medicare Part A?

Q. What are the coordinated care enrollment rules for Medicare beneficiaries who are *not* entitled to Part A of Medicare?

A. If you are not entitled to Part A, you may still enroll in a plan that has a Medicare contract. The plan, however, has the right to require that you pay a premium for services covered by Part A if you enroll as a Medicare member.

What If I'm Entitled To Both Medicaid And Medicare?

Q. Can a Medicaid recipient who is also eligible for Medicare join a coordinated care plan that has a contract with Medicare?

A. Yes. If you are eligible for Medicare and currently receiving Medicaid benefits, the State Medicaid program may pay the Medicare Part B premium and, where necessary, the Medicare Part A premium, so that you can receive medical services under Medicare. For more information contact your State Medicaid office.

Effective Date Of Plan Coverage

Q. If I enroll in a coordinated care plan, when does my coverage begin?

A. Depending on the plan, coverage can begin either the first day of the month after your enrollment application is received by the plan or up to three months later. The plan will give you written information explaining your coverage and when it goes into effect.

Using Non-Plan Doctors

Q. Must I always go to the health care providers affiliated with the plan?

A. Most plans that serve Medicare beneficiaries have "lock-in" provisions in their contracts. This means that as a plan member you are generally "locked-in" to receiving care from the plan's providers. With few exceptions, if you go outside the plan for services, neither the plan nor Medicare will pay for those services. The lock-in does not apply to emergency services, which you may receive anywhere, urgently needed care, which you may receive while you are temporarily away from the plan's service area, or for services provided by a non-plan provider to whom the plan referred you. This information is included in the plan's membership packet which also includes a list of plan providers. If you join a plan with a lock-in provision, you will receive a letter from the Medicare program that explains the lock-in provision and confirms your enrollment in the plan. If you enroll in a plan that does not have a lock-in requirement, you can use non-plan health care professionals. While the plan will not pay if you use non-plan providers, Medicare will still pays its share for covered services. In such instances, you would be responsible for paying Medicare's coinsurance, deductibles and other permissible charges, just as if you were receiving care under the traditional fee-for-service system.

Frequent Travellers And Coordinated Care

Q. Should I join a coordinated care plan if I travel frequently?

A. That is a decision that only you can make. However, there are some things which you should think about when you make that decision. For example, a plan member who is temporarily away from the plan's service area is not entitled to coverage of any care other than emergency or urgently-needed services. If you travel frequently you should keep this in mind when deciding whether or not to join a plan that requires you to use only the plan providers. Some plans arrange with plans in other areas to provide health care services to their members travelling or visiting that area. Information about any such arrangement should be obtained from the plan you are considering joining.

Moving Out Of Your Plan's Service Area

Q. What happens if I move from the plan's service area?

A. If you move from the service area or you plan to be away from the service area for more than 90 days at a time, you must notify the plan. Generally, you will be disenrolled from the plan if you have moved permanently or the absence lasts longer than 90 days. Plans are permitted to retain members whose absences from the plan's service area are temporary. Some restrictions may apply to this provision. If you are a member of a plan or, if you are thinking about joining a plan, you need to contact the plan to see if this option is available to you and what restrictions apply.

Checking Your Enrollment Status

Q. How can I tell whether my enrollment in, or disenrollment from, a coordinated care plan has taken effect?

A. The Social Security Administration (SSA) can give you that information. Additionally, if your bills for Medicare services are not being paid because you recently joined a plan or changed from one plan to another, the SSA office can help you straighten out any problems.

How To Disenroll

Q. How does a person disenroll from a coordinated care plan?

A. You can voluntarily disenroll for any reason by mailing or delivering in another manner a signed and dated request for disenrollment to the plan or to a Social Security Administration office. (If you are receiving railroad retirement benefits, the request would go to the office of the Railroad Retirement Board.) Your disenrollment will be effective the first day of the month after your signed disenrollment request is received by either the plan or the Social Security office.

Switching Plans

Q. Can I disenroll from one plan and join another?

A. If you want to change from one plan to another, you may do so by simply enrolling in the new plan as long as it has a Medicare contract. You are automatically disenrolled from the old plan.

Involuntary Disenrollment

Q. Can a plan disenroll me without my permission?

A. Yes. You can be disenrolled for any of the following reasons:

- you discontinue your Medicare Part B coverage.
- you fail to pay premiums or approved copayments charged by the plan and the plan has given you a reasonable chance to make the payments.
- you move out of the plan's service area, or you leave the area for more than 90 consecutive days.
- you commit fraud or permit abuse of the plan membership card.
- your behavior is disruptive, unruly, abusive, or uncooperative to the extent that your continuing membership seriously impairs the plan's ability to furnish services to either you or other members. The Health Care Financing Administration must first approve the plan's disenrollment for this reason.

- the plan's Medicare contract is cancelled or is not renewed. In either case, you would be given the opportunity to enroll in another plan (if one is in the area) or return to traditional fee-for-service Medicare.

The plan must attempt to contact you under any of these conditions and then provide a written notice regarding the disenrollment action. The notice will provide an opportunity for you to respond before disenrollment occurs.

Membership Costs

Q. What will membership in a coordinated care plan cost a Medicare beneficiary?

A. Membership costs vary by plan. For Medicare-covered services, a plan is not allowed to charge a Medicare beneficiary more than an amount set by HCFA. Each year HCFA informs the plans of this maximum amount and the plans must notify their Medicare enrollees. Depending on the plan, you may have to pay a monthly premium, a deductible, and copayments or coinsurance for certain services. Plans may also offer expanded coverage at a higher premium. Remember that you are *always responsible* for payment of your Medicare Part B premium. If you receive a monthly Social Security check, this is the premium that is withheld from your check. This obligation is separate from your payment to the plan.

Medicare Helps Pay For Your Plan Benefits

Q. Does Medicare make a payment to the plan on my behalf?

A. The payment made by the Federal Government for each enrolled Medicare beneficiary varies by plan. In most plans, the payment is based on the location of the plan and the amount it would cost the Medicare program if the Medicare beneficiary received services under the traditional fee-for-service program.

Your Right To Plan Services

Q. What should I do if my plan refuses to provide or pay for a service covered by Medicare?

A. If the plan refuses to pay for any service, or refuses to provide a Medicare-covered service, and you believe it should pay for or provide the service, you may make a written appeal to the plan. Federal regulations require plans to follow special appeals requirements in the following situations:

- the plan has refused to provide a Medicare-covered service, or
- you received a service covered by Medicare, and you or the provider billed the plan for the service and the plan refused to pay.

The information provided to you when you join a plan will explain your appeal rights.

Complaints

Q. What happens if I have a complaint about my plan that is not related to payments?

A. If you have a complaint about the quality of care received from a plan, you can follow your plan's grievance procedure or complain to the Medicare Peer Review Organization (PRO) in your area. These organizations are made up of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients. If the complaint is about deceptive or misleading advertising, questionable enrollment or marketing practices, long waiting periods for appointments, and related matters, you should file your complaint with the plan. You may also write to the nearest Health Care Financing Administration regional office.

Different Types Of Plans

Q. Are there different types of coordinated care plans?

A. Yes. There are two basic types of plans, the *staff or medical group model* and the *individual practice model*. Staff and group model plans generally provide services from central locations where doctors, laboratories and other services are located. Individual practice model plans are made up of doctors located in their own offices. Each of these models has strong points. Staff and group model plans may be more convenient for you since they provide most services at the same location. Individual practice plans may have more doctors to choose from. If your current doctor is a member of either of these models, you will generally still be able to see him or her after you join the plan.

Who Selects My Doctor?

Q. If I join a plan, will I always have the same doctor?

A. Most plans allow you to select a primary care doctor from those affiliated with the plan. If you do not make a selection, a primary care doctor will be assigned to you. Your primary care doctor is responsible for managing your medical care. In fact, all health care services, including hospital admissions and the services of medical specialists, are obtained through your designated primary care doctor. If for any reason you want to change your primary care doctor, the plan generally will let you do so as long as you pick another one from the plan's primary care doctors.

Q. Do coordinated care plans provide preventive health care and other services that are not covered by Medicare?

Preventive Care

A. Yes. Most plans provide routine physicals as part of a larger program of preventive medicine. Usually the preventive care approach includes such non-Medicare covered services as immunizations, health education, and dental care. Plans also often cover eyeglasses and hearing aids and the examinations to fit them. Some plans provide some or all of these services at no additional cost while others may charge a nominal fee. You can ask the plan what services are provided that are in addition to the basic Medicare covered benefits and if these services will cost you an additional fee.

Q. Why do people join coordinated care plan?

Why Join A Plan?

A. People join coordinated care plans for several reasons. The most frequently mentioned include:

- It's generally easier to get care through one source (for example, doctors' services, hospital care, laboratory tests, X-rays, etc.), and most of the services are available at a central location.
- Quality of care may be enhanced because of the coordination of medical services.
- You can more easily budget health care costs because you know the amount of any premiums in advance, and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.
- In many cases, benefits beyond those covered by Medicare are available at either no additional charge or a nominal charge. Extra benefits may include prescription drugs, physicals, immunizations, dental care, eyeglasses and hearing aids.

Q. Where can I get more information about coordinated care plans that serve the area where I live?

Finding A Plan

A. Staff at the Health Care Financing Administration regional offices listed below can tell you if there are coordinated care plans in your area that contract with Medicare. This information is also available by calling **1-800-638-6833**.

Boston: (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont) Beneficiary Services Branch (617) 565-1232.

Finding A Plan

Atlanta: (Alabama, North and South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee) Beneficiary Services and HMO Branch (404) 331-2549.

Chicago: (Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin) Beneficiary Services and HMO Branch (312) 353-7180.

Dallas: (Arkansas, Louisiana, New Mexico, Oklahoma and Texas) Beneficiary Services Branch (214) 767-6401.

Kansas City: (Iowa, Kansas, Missouri and Nebraska) Program Services Branch (816) 426-2866.

Denver: (Colorado, Montana, North and South Dakota, Utah and Wyoming) Beneficiary Services Branch (303) 844-4024 extension 238.

San Francisco: (American Samoa, Arizona, California, Guam, Hawaii and Nevada) Beneficiary Services Branch (415) 744-3617.

Seattle: (Alaska, Idaho, Oregon and Washington) Beneficiary Services Branch (206) 553-0800.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. (Medicare payments based on benefit periods, see page 14).	First 60 days	All but $676	$676
	61st to 90th day	All but $169 a day	$169 a day
	91st to 150th day[1]	All but $338 a day	$338 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.[2] (Medicare payments based on benefit periods, see page 14.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $84.50 a day	$84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	If you elect the hospice option and as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1993 Part A monthly premium: None for most beneficiaries.
$221 if you must buy Part A (Premium may be higher if you enroll late).

[1] This 60-reserve-days benefit may be used only once in a lifetime.
[2] Neither Medicare nor private Medigap insurance will pay for most nursing home care.
[3] To the extent the blood deductible is met under Part B of Medicare during the calendar year, it does not have to be met under Part A.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, ambulance, diagnostic tests, and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible,[1] plus 20% of approved amount and limited charges above approved amount.
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care for as long as you meet conditions for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).[2]

1993 Part B monthly premium: $36.60 (Premium may be higher if you enroll late).

[1] Once you have had $100 of expenses for covered services in 1993, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

[2] To the extent the blood deductible is met under Part A of Medicare during the calendar year, it does not have to be met under Part B.

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